New Jersey Department of Health and Senior Services
Health Insurance Continuation Program
P O Box 363
Trenton, NJ 08625-0363

FOR STATE USE ONLY
Record #

CONFIDENTIALITY RELEASE

Name of Applicant (Patient)	Social Security Number
Street Address	
City, State, Zip Code	

I understand every attempt to maintain strict confidentiality surrounding all my medical conditions is provided by the New Jersey Department of Health and Senior Services, Health Insurance Continuation Program (HICP).

I am aware that information concerning the New Jersey Department of Health and Senior Services, Health Insurance Continuation Program (HICP) is available for public dissemination and can be located on the internet, in brochures, telephone books and other public sources.

I understand HICP is a public program and eligibility requirements may be disseminated in information-seeking phone calls. I further understand that HICP will contact my employer if my insurance is carried through an employer-sponsored group plan, making every attempt to safeguard my confidentiality.

I understand that while every attempt to maintain strict confidentiality surrounding all my medical conditions is provided by HICP, I do not hold the New Jersey Department of Health and Senior Services, HICP responsible for any indirect breach of confidentiality relative to public information.

Signature of Applicant (Patient) or Guardian	Date
Signature of Spouse, if Married	Date
Name of Witness (Print)	
Signature of Witness	Date

Applicant: Forward this completed Confidentiality Release form to the Health Insurance Continuation Program, along with your Application.